CENTERS FOR MEDICARE & MEDICAID SERVICES 45 4/27/14 OMB NO. 0938-0									
STATEMENT OF DESIGNATION (VAL) PROLINGENIA (VAL)									
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MOUTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED								
	1								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	•								
IVY HALL NURSING HOME 301 WATAUGA AVE									
ELIZABETHTON, TN 37643									
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFEREN									
K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 K018	•								
Doors protecting corridor openings in other than									
required enclosures of vertical openings, exits, of the									
hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core practices were in compliance with the applicable standard of care, but that in									
wood, or capable of resisting fire for at least 20 order to respond to this citation from the									
minutes. Doors in sprinklered buildings are only surveyors, the facility is taking the									
required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors									
are provided with a means suitable for keeping									
the door closed. Dutch doors meeting 19.3.6.3.6									
are permitted. 19.3.6.3 On 3/17/14, the Maintenance Director repaired resident room doors 207, 201,									
Roller latches are prohibited by CMS regulations 202 203 201 and 204 co they would									
in all health care facilities.									
Identification of Other Areas with Potential to be Affected									
On 3/25/14, the Maintenance Director									
inspected corridor doors and found no									
other areas to be affected.									
This STANDARD is not met as evidenced by: Based on observation, it was determined that the									
facility failed to ensure corridor doors closed to a The Maintenance Director will conduct a									
positive latch. monthly audit to ensure that corridor									
The findings include: doors latch to a positive latch.									
Observation on March 10, 2014 at 12:40 p.m.									
revealed the following doors did not close to a The Maintenance Director will report his									
positive latch: findings monthly to the Performance									
1. Resident room 207 Improvement Committee for review and									
2. Resident room 202 to determine ongoing compliance. The									
4. Resident room 303 Performance Committee consists of the									
5. Resident room 301 Administrator, Assistant Administrator,									
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE (X6) DATE									
YMAY AMPEN LUL XITUCEN HIMINISTRATOR 3-28-14									
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days									
following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.	14 1								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4YZ121

Facility ID: TN1003

If continuation sheet Page 1 of 6

PRINTED: 03/13/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING A 445469 03/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE IVY HALL NURSING HOME ELIZABETHTON, TN 37643 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Director of Nursing, Assistant Director of K 018 Continued From page 1 K 018 Nursing, Social Services Director, Business Resident room 304 Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry These findings were verified by the maintenance Director, Activities Director, Medical director and acknowledged by the administrator Records Director, Human Resource during the exit conference on March 10. Manager, MDS Coordinator, Medical K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 3/25/14 Director, and Consultant Pharmacist. SS=D One hour fire rated construction (with 34 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When K029 the approved automatic fire extinguishing system option is used, the areas are separated from Ivy Hall Nursing Home believes its current other spaces by smoke resisting partitions and practices were in compliance with the doors. Doors are self-closing and non-rated or applicable standard of care, but that in field-applied protective plates that do not exceed 48 inches from the bottom of the door are order to respond to this citation from the permitted. 19.3.2.1 surveyors, the facility is taking the following additional actions: **Corrective Actions for Targeted Area** This STANDARD is not met as evidenced by: On 3/18/14, the Maintenance Director Based on observation, it was determined that the installed door closers on the facility failed to have self-closing doors in housekeeping storage and general hazardous areas. storage doors in the employee lounge located in "A" Building. The findings include: Observation on March 10, 2014 at 12:00 p.m.

revealed that the house keeping storage room

and the general storage room in the employee lounge in the A Building are not self-closing and

This finding was verified by the maintenance

director and acknowledged by the administrator during the exit conference on March 10, 2014.

are over 50 square feet with combustible storage.

Identification of Other Areas with

On 3/25/14, the Maintenance Director

audited storage areas over 50 square feet in the facility and found no other areas

Potential to be Affected

had been affected.

PRINTED: 03/13/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING A 445469 B. WING 03/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE IVY HALL NURSING HOME **ELIZABETHTON, TN 37643** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ŧΟ (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 018 Continued From page 1 K 018 Resident room 304 These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10. NFPA 101 LIFE SAFETY CODE STANDARD K 029 K 029 **Systematic Changes** SS=D One hour fire rated construction (with 1/4 hour The Maintenance Director will conduct a fire-rated doors) or an approved automatic fire quarterly audit of the facility so that extinguishing system in accordance with 8.4.1 storage areas that are greater than 50 and/or 19.3.5.4 protects hazardous areas. When square feet with combustibles have had a the approved automatic fire extinguishing system self-closing door installed. option is used, the areas are separated from other spaces by smoke resisting partitions and **Monitoring** doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed The Maintenance Director will report his 48 inches from the bottom of the door are findings quarterly to the Performance permitted. 19.3.2.1 Improvement Committee for review and to determine ongoing compliance. The Performance Committee consists of the Administrator, Assistant Administrator, This STANDARD is not met as evidenced by: Director of Nursing, Assistant Director of Based on observation, it was determined that the Nursing, Social Services Director, Business facility failed to have self-closing doors in Office Manager, Maintenance Director, hazardous areas. Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical The findings include: Records Director, Human Resource Manager, MDS Coordinator, Medical Observation on March 10, 2014 at 12:00 p.m. 3/25/14 Director, and Consultant Pharmacist. revealed that the house keeping storage room and the general storage room in the employee lounge in the A Building are not self-closing and are over 50 square feet with combustible storage. This finding was verified by the maintenance

director and acknowledged by the administrator during the exit conference on March 10, 2014.

FORM APPROVED								
CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES					0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING A			(X3) DATE SURVEY COMPLETED			
		445469	B. WING			03/	10/2014	
NAME OF !	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	-	
IVY HALI	L NURSING HOME		ł	3	01 WATAUGA AVE			
				E	LIZABETHTON, TN 37643			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (CIENCY)	BE	(X5) COMPLETION DATE	
K 066 SS≂D	NFPA 101 LIFE SA	FETY CODE STANDARD	κc)66	К066			
	less than the follow (1) Smoking is proh- compartment where combustible gases, and in any other ha area is posted with or with the internation (2) Smoking by pati responsible is prohi direct supervision. (3) Ashtrays of non- design are provided permitted. (4) Metal containers devices into which a	nibited in any room, ward, or elfammable liquids, or oxygen is used or stored zardous location, and such signs that read NO SMOKING onal symbol for no smoking. Ients classified as not bited, except when under combustible material and safe in all areas where smoking is swith self-closing cover ashtrays can be emptied are all areas where smoking is			Ivy Hall Nursing Home believes its or practices were in compliance with the applicable standard of care, but the order to respond to this citation from surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Area on 3/17/14, the Maintenance Directions installed a metal container with a second closing cover into which ashtrays locat "A" Building's front entrance smooth area can be emptied. Identification of Other Areas with Potential to be Affected On 3/18/14, the Maintenance Directions pected other designated smoking areas and found no other areas to be affected.	t in the tarent torested oking		
	Based on observat facility failed to prov self-closing lids to a to be emptied into. The findings include Observation on Mar	rch 10, 2014 at 12:10 p.m.	•		Systematic Changes The Maintenance Director will inspedesignated smoking areas monthly tensure proper placement of self-closmetal ash containers. Identification of Other Areas with Potential to be Affected	o sing		
	revealed that the AI	Building front entrance		- 1	On 3/18/14, the Maintenance Direct	tor		

smoking area is not provided with metal

DEPARTMENT OF HEALTH AND HUMAN SERVICES

inspected other designated smoking

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PRINTED: 03/13/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING A 445469 03/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE IVY HALL NURSING HOME **ELIZABETHTON, TN 37643** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY)** areas and found no other areas to be K 066 Continued From page 3 K 0661 affected. containers with self-closing lids to all smoking areas for ashtrays to be emptied into. The facility **Systematic Changes** has 3 smoking areas. The Maintenance Director will inspect This finding was verified by the maintenance designated smoking areas monthly to director and acknowledged by the administrator ensure proper placement of self-closing during the exit conference on March 10, 2014. metal ash containers. K 130 NFPA 101 MISCELLANEOUS K 130 SS=D Monitoring OTHER LSC DEFICIENCY NOT ON 2786 The Maintenance Director will report his findings monthly to the Performance Improvement Committee for review and to determine ongoing compliance. The This STANDARD is not met as evidenced by: Based on observation, it was determined that the Performance Committee consists of the facility failed to have fire doors close and latch Administrator, Assistant Administrator, within their frame. Director of Nursing, Assistant Director of Nursing, Social Services Director, Business The findings include: Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Observation on March 10, 2014 at 12:55 p.m. Director, Activities Director, Medical revealed the A Building and B Building separation Records Director, Human Resource is with 90 minute fire rated doors. These 90 Manager, MDS Coordinator, Medical minute fire rated doors are not provided with 3/18/14 latching and panic hardware. Director, and Consultant Pharmacist. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10, 2014. K130 Actual NFPA Standard: NFPA 80 2-1.4 Operation of Doors. Ivy Hall Nursing Home believes its current

categories.

All swinging doors shall be closed and latched at

the time of fire. For the purposes of this section,

the operation of doors is divided into three

practices were in compliance with the

applicable standard of care, but that in

surveyors, the facility is taking the following additional actions:

order to respond to this citation from the

PRINTED: 03/13/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING A 445469 B. WING 03/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE **IVY HALL NURSING HOME ELIZABETHTON, TN 37643** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ΙD (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 066 Continued From page 3 K 0661 **Corrective Actions for Targeted Area** containers with self-closing lids to all smoking On 3/19/14, the Maintenance Director areas for ashtrays to be emptied into. The facility placed an order with Trimble Door has 3 smoking areas. Company for the installation of latching panic hardware on 90-minute fire doors This finding was verified by the maintenance director and acknowledged by the administrator between "A" and "B" buildings. during the exit conference on March 10, 2014, K 130 **Identification of Other Areas with** NFPA 101 MISCELLANEOUS K 130 Potential to be Affected SS=D OTHER LSC DEFICIENCY NOT ON 2786 On 3/17/14, the Maintenance Director inspected the other fire doors in the facility and found that no other doors were affected. This STANDARD is not met as evidenced by: Based on observation, it was determined that the **Systematic Changes** facility failed to have fire doors close and latch within their frame. The Maintenance Director will inspect self-closing doors monthly for proper The findings include: operation and latching hardware. Observation on March 10, 2014 at 12:55 p.m. Monitoring revealed the A Building and B Building separation is with 90 minute fire rated doors. These 90 The Maintenance Director will report his minute fire rated doors are not provided with findings monthly to the Performance latching and panic hardware. Improvement Committee for review and to determine ongoing compliance. The This finding was verified by the maintenance Performance Committee consists of the director and acknowledged by the administrator Administrator, Assistant Administrator, during the exit conference on March 10, 2014. Director of Nursing, Assistant Director of Actual NFPA Standard: NFPA 80 Nursing, Social Services Director, Business 2-1.4 Operation of Doors. Office Manager, Maintenance Director, All swinging doors shall be closed and latched at Dietary Manager, Housekeeping /Laundry the time of fire. For the purposes of this section,

categories.

the operation of doors is divided into three

Director, Activities Director, Medical

Manager, MDS Coordinator, Medical

Director, and Consultant Pharmacist.

Records Director, Human Resource

4/15/14